103D CONGRESS
1ST SESSION

S. 1426

To amend title XVIII of the Social Security Act and the Budget and Emergency Deficit Control Act of 1985 with respect to essential access community hospitals, the rural transition grant program, durable medical equipment, adjustments to discretionary spending limits, standards for medicare supplemental insurance policies, expansion and revision of medicare select policies, psychology services in hospitals, payment for anesthesia services furnished directly or concurrently in providers, improve reimbursement for clinical social worker services, and for other purposes.

IN THE SENATE OF THE UNITED STATES

AUGUST 6 (legislative day, JUNE 30), 1993

Mr. CONRAD (for himself, Mr. INOUYE, and Mr. BINGAMAN) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act and the Budget and Emergency Deficit Control Act of 1985 with respect to essential access community hospitals, the rural transition grant program, durable medical equipment, adjustments to discretionary spending limits, standards for medicare supplemental insurance policies, expansion and revision of medicare select policies, psychology services in hospitals, payment for anesthesia services furnished directly or concurrently in providers, improve reimbursement for clinical social worker services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCES IN ACT.

(a) SHORT TITLE.—This Act may be cited as the "Essential Medicare Amendments of 1993".

(b) REFERENCES IN ACT.—Except as otherwise specifically provided, whenever in this Act, an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

SEC. 2. ESSENTIAL ACCESS COMMUNITY HOSPITAL (EACH) AMENDMENTS.

(a) INCREASING NUMBER OF PARTICIPATING STATES.—Section 1820(a)(1) (42 U.S.C. 1395i–4(a)(1)) is amended by striking "7" and inserting "9".

(b) TREATMENT OF INPATIENT HOSPITAL SERVICES PROVIDED IN RURAL PRIMARY CARE HOSPITALS.—

(1) IN GENERAL.—Section 1820(f)(1)(F) (42 U.S.C. 1395i–4(f)(1)(F)) is amended to read as follows:

"(F) subject to paragraph (4), provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for providing inpatient care to patients requiring sta-

bilization before discharge or transfer to a hospital, except that the facility may not provide any inpatient hospital services—

"(i) to any patient whose attending physician does not certify that the patient may reasonably be expected to be discharged or transferred to a hospital within 72 hours of admission to the facility; or

"(ii) consisting of surgery or any other service requiring the use of general anesthesia (other than surgical procedures specified by the Secretary under section 1833(i)(1)(A)), unless the attending physician certifies that the risk associated with transferring the patient to a hospital for such services outweighs the benefits of transferring the patient to a hospital for such services.".

(2) LIMITATION ON AVERAGE LENGTH OF STAY.—Section 1820(f) (42 U.S.C. 1395i–4(f)) is amended by adding at the end the following new paragraph:

"(4) LIMITATION ON AVERAGE LENGTH OF INPATIENT STAYS.—The Secretary may terminate a designation of a rural primary care hospital under

paragraph (1) if the Secretary finds that the average length of stay for inpatients at the facility during the previous year in which the designation was in effect exceeded 72 hours. In determining the compliance of a facility with the requirement of the previous sentence, there shall not be taken into account periods of stay of inpatients in excess of 72 hours to the extent such periods exceed 72 hours because transfer to a hospital is precluded because of inclement weather or other emergency conditions.".

(3) CONFORMING AMENDMENT.—Section 1814(a)(8) (42 U.S.C. 1395f(a)(8)) is amended by striking "such services" and all that follows and inserting "the individual may reasonably be expected to be discharged or transferred to a hospital within 72 hours after admission to the rural primary care hospital.".

(4) GAO REPORTS.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit reports to the Congress on—

(A) the application of the requirements under paragraphs (1)(F) and (4) of section 1820(f) of the Social Security Act (as amended by this subsection); and

(B) the extent to which such requirements have resulted in such hospitals providing inpatient care beyond their capabilities or have limited the ability of such hospitals to provide needed services.

(c) DESIGNATION OF HOSPITALS.—

(1) PERMITTING DESIGNATION OF HOSPITALS LOCATED IN URBAN AREAS.—

(A) IN GENERAL.—Section 1820 (42 U.S.C. 1395i–4) is amended—

(i) by striking paragraph (1) of subsection (e) and redesignating paragraphs (2) through (6) of subsection (e) as paragraphs (1) through (5);

(ii) in subsection (e)(1)(A), as redesignated by subparagraph (A)—

(I) by striking "is located" and inserting "except in the case of a hospital located in an urban area, is located"

(II) by striking ", (ii)" and inserting "or (ii)", and

(III) by striking "or (iii)" and all that follows through "section,"; and

(iii) in subsection (i)(1)(B), by striking "paragraph (3)" and inserting "paragraph (2)".

(B) NO CHANGE IN MEDICARE PROSPECTIVE PAYMENT.—Section 1886(d)(5)(D) (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(i) in clause (iii)(III), by inserting "located in a rural area and" after "that is", and

(ii) in clause (v), by inserting "located in a rural area and" after "in the case of a hospital".

(2) PERMITTING HOSPITALS LOCATED IN ADJOINING STATES TO PARTICIPATE IN STATE PROGRAM.—

(A) IN GENERAL.—Section 1820 (42 U.S.C. 1395i–4) is amended—

(i) by redesignating subsection (k) as subsection (l); and

(ii) by inserting after subsection (j) the following new subsection:

"(k) ELIGIBILITY OF HOSPITALS NOT LOCATED IN PARTICIPATING STATES.—Notwithstanding any other provision of this section—

"(1) for purposes of including a hospital or facility as a member institution of a rural health network, a State may designate a hospital or facility that is not located in the State as an essential access community hospital or a rural primary care hospital if the hospital or facility is located in an adjoining State and is otherwise eligible for designation as such a hospital;

"(2) the Secretary may designate a hospital or facility that is not located in a State receiving a grant under subsection (a)(1) as an essential access community hospital or a rural primary care hospital if the hospital or facility is a member institution of a rural health network of a State receiving a grant under such subsection; and

"(3) a hospital or facility designated pursuant to this subsection shall be eligible to receive a grant under subsection (a)(2).".

(B) CONFORMING AMENDMENTS.—(i) Section 1820(c)(1) (42 U.S.C. 1395i–4(c)(1)) is amended by striking "paragraph (3)" and inserting "paragraph (3) or subsection (k)".

(ii) Paragraphs (1)(A) and (2)(A) of section 1820(i) (42 U.S.C. 1395i–4(i)) are each amended—

(I) in clause (i), by striking "(a)(1)" and inserting "(a)(1) (except as provided in subsection (k))", and

(II) in clause (ii), by striking "subparagraph (B)" and inserting "subparagraph (B) or subsection (k)".

(d) SKILLED NURSING SERVICES IN RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(3) (42 U.S.C. 1395i–4(f)(3)) is amended by striking "because the facility" and all that follows and inserting the following: "because, at the time the facility applies to the State for designation as a rural primary care hospital, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed the total number of licensed inpatient beds at the time the facility applies to the State for such designation (minus the number of inpatient beds used for providing inpatient care pursuant to paragraph (1)(F)). For purposes of the previous sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled

nursing facility at the time the facility applies to the State for designation as a rural primary care hospital.".

(e) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—Section 1834(g)(1) (42 U.S.C. 1395m(g)(1)) is amended by adding at the end the following:

"The amount of payment shall be determined under either method without regard to the amount of the customary or other charge.".

(f) CLARIFICATION OF PHYSICIAN STAFFING REQUIREMENT FOR RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(1)(H) (42 U.S.C. 1395i–4(f)(1)(H)) is amended by striking the period and inserting the following: ", except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).".

(g) TECHNICAL AMENDMENTS RELATING TO PART A DEDUCTIBLE, COINSURANCE, AND SPELL OF ILLNESS.—(1) Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)) is amended—

(A) by striking "inpatient hospital services" the first place it appears and inserting "inpatient hos-

pital services or inpatient rural primary care hospital services";

(B) by striking "inpatient hospital services" the second place it appears and inserting "such services"; and

(C) by striking "and inpatient rural primary care hospital services".

(2) Sections 1813(a) and 1813(b)(3)(A) (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended by striking "inpatient hospital services" each place it appears and inserting "inpatient hospital services or inpatient rural primary care hospital services".

(3) Section 1813(b)(3)(B) (42 U.S.C. 1395e(b)(3)(B)) is amended by striking "inpatient hospital services" and inserting "inpatient hospital services, inpatient rural primary care hospital services,".

(4) Section 1861(a) (42 U.S.C. 1395x(a)) is amended—

(A) in paragraph (1), by striking "inpatient hospital services" and inserting "inpatient hospital services, inpatient rural primary care hospital services,"; and

(B) in paragraph (2), by striking "hospital" and inserting "hospital or rural primary care hospital".

(h) AUTHORIZATION OF APPROPRIATIONS.—Section 1820(l) (42 U.S.C. 1395i–4(l)), as redesignated by subsection (c)(2), is amended by striking "1990, 1991, and 1992" and inserting "1990 through 1995".

(i) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 3. REAUTHORIZATION OF RURAL TRANSITION GRANT PROGRAM.

Section 4005(e)(9) of the Omnibus Budget Reconciliation Act of 1987, as amended by section 6003(g)(1)(B) of the Omnibus Budget Reconciliation Act of 1989, is amended by striking "1992" and inserting "1992 and $30,000,000 for each of fiscal years 1993 through 1997".

SEC. 4. DURABLE MEDICAL EQUIPMENT.

(a) DEFINITION OF MEDICAL EQUIPMENT AND SUPPLIES.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"MEDICAL EQUIPMENT AND SUPPLIES

"(oo) The term 'medical equipment and supplies' means—

"(1) durable medical equipment (as defined in section 1861(n));

"(2) prosthetic devices (as described in section 1861(s)(8));

"(3) orthotics and prosthetics (as described in section 1861(s)(9));

"(4) home dialysis supplies and equipment (as described in section 1861(s)(2)(F));

"(5) surgical dressings and other devices (as described in section 1861(s)(5));

"(6) immunosuppressive drugs (as described in section 1861(s)(2)(J)); and

"(7) such other items as the Secretary may determine.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items furnished on or after January 1, 1994.

(b) DEVELOPMENT AND APPLICATION OF NATIONAL STANDARDS FOR SUPPLIERS OF MEDICAL EQUIPMENT AND SUPPLIES.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(i) REQUIREMENTS FOR ISSUANCE AND RENEWAL OF SUPPLIER NUMBERS FOR SUPPLIERS OF MEDICAL EQUIPMENT AND SUPPLIES.—

"(1) PAYMENT.—No payment may be made under this part after July 1, 1994, for items fur-

nished by a supplier of medical equipment and supplies (as defined in section 1861(oo)) unless such supplier meets the national standards specified by the Secretary and possesses a valid supplier number.

"(2) REVISED STANDARDS.—

"(A) IN GENERAL.—Not later than January 1, 1996, the Secretary shall, in consultation with representatives of suppliers of medical equipment and supplies, carriers, and consumers, revise the national standards for suppliers of medical equipment and supplies to include the requirements listed in subparagraph (B).

"(B) STANDARDS DESCRIBED.—The requirements listed in this subparagraph are that suppliers of medical equipment and supplies shall—

"(i) comply with all applicable State and Federal licensure and regulatory requirements;

"(ii) maintain a physical facility on an appropriate site;

"(iii) have proof of appropriate liability insurance; and

"(iv) meet such other requirements as the Secretary may specify.

"(C) APPLICABILITY OF REVISED STANDARDS.—Beginning after December 31, 1995, each supplier of medical equipment and supplies applying for a supplier number or renewing such supplier's supplier number shall meet the revised standards described in this paragraph.".

(c) CERTIFICATES OF MEDICAL NECESSITY.—

(1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m), as amended by subsection (b), is amended—

(A) in subsection (a), by striking paragraph (16), and

(B) by adding at the end the following new subsection:

"(j) CERTIFICATES OF MEDICAL NECESSITY.—

"(1) STANDARDIZED CERTIFICATES.—Not later than July 1, 1994, the Secretary shall, in consultation with carriers under this part, develop one or more standardized certificates of medical necessity (as defined in paragraph (3)) for medical equipment and supplies (as defined in section 1861(oo) other than paragraphs (4), (6), and (7)). If a certificate of medical necessity is required by the Secretary, such standardized certificates shall—

"(A) be completed by each physician who prescribes such medical equipment and supplies for any beneficiary under this part, and

"(B) be transmitted to the supplier and then to the carrier processing the claim for payment for such medical equipment and supplies under this part.

"(2) PROHIBITION AGAINST DISTRIBUTION BY SUPPLIERS OF CERTIFICATES OF MEDICAL NECESSITY.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a supplier of medical equipment and supplies described in paragraph (1) may not distribute to physicians or to individuals entitled to benefits under this part for commercial purposes any completed or partially completed certificates of medical necessity.

"(B) EXCEPTION FOR CERTAIN BILLING INFORMATION.—Subparagraph (A) shall not apply with respect to a certificate of medical necessity to the extent that such certificate contains only information completed by the supplier of medical equipment and supplies identifying such supplier and the beneficiary to whom such medical equipment and supplies are fur-

nished, a description of such medical equipment and supplies, any product code identifying such medical equipment and supplies, and any other administrative information identified by the Secretary. In the event a supplier provides a certificate of medical necessity containing information permitted under this subparagraph, such certificate shall also contain the supplier's charge and the fee schedule amount for the medical equipment or supplies being furnished prior to distribution of such certificate to the physician.

"(C) PENALTY.—Any supplier of medical equipment and supplies who knowingly and willfully distributes a certificate of medical necessity in violation of subparagraph (A) is subject to a civil money penalty in an amount not to exceed $1,000 for each such certificate of medical necessity so distributed. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a).

"(3) DEFINITION.—For purposes of this subsection, the term 'certificate of medical necessity' means a form or other document containing information required by the Secretary to be submitted to show that a covered item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to certificates of medical necessity on or after January 1, 1994.

(d) COVERAGE AND REVIEW CRITERIA FOR CERTAIN MEDICAL EQUIPMENT AND SUPPLIES.—Section 1834 (42 U.S.C. 1395m), as amended by subsection (c), is amended by adding at the end the following new subsection:

"(k) COVERAGE AND REVIEW CRITERIA.—

"(1) DEVELOPMENT AND ESTABLISHMENT.—Not later than July 1, 1994, the Secretary, in consultation with representatives of suppliers of medical equipment and supplies (as defined in section 1861(oo) other than paragraphs (4), (6), and (7)), individuals enrolled under this part, and appropriate medical specialty societies, shall develop and establish uniform national coverage and utilization review

criteria for 200 items of medical equipment and supplies (as so defined) selected in accordance with the standards described in paragraph (2). The Secretary shall publish the criteria as part of the instructions provided to fiscal intermediaries and carriers under this part and no further publication, including publication in the Federal Register, shall be required.

"(2) STANDARDS FOR SELECTING ITEMS SUBJECT TO CRITERIA.—The Secretary may select an item for coverage under the criteria developed and established under paragraph (1) if the Secretary finds that—

"(A) the item is frequently purchased or rented by beneficiaries;

"(B) the item is frequently subject to a determination that such item is not medically necessary; or

"(C) the coverage or utilization criteria applied to the item (as of the date of the enactment of this subsection) is not consistent among carriers.

"(3) ANNUAL REVIEW AND EXPANSION OF ITEMS SUBJECT TO CRITERIA.—The Secretary shall annually review the coverage and utilization of items of medical equipment and supplies to determine

whether items not included among the items selected under paragraph (1) should be made subject to uniform national coverage and utilization review criteria, and, if appropriate, shall develop and apply such criteria to such additional items.

"(4) REPORT ON EFFECT OF UNIFORM CRITERIA ON UTILIZATION OF ITEMS.—Not later than January 1, 1995, the Secretary shall submit a report to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate analyzing the impact of the uniform criteria established under paragraph (1) on the utilization of items of medical equipment and supplies by individuals enrolled under this part.".

(e) PROHIBITION AGAINST MULTIPLE SUPPLIER NUMBERS.—

(1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m), as amended by subsection (d), is amended by adding at the end the following new subsection:

"(l) PROHIBITION AGAINST MULTIPLE SUPPLIER NUMBERS FOR SUPPLIERS OF MEDICAL EQUIPMENT AND SUPPLIES.—The Secretary may not issue more than one supplier number to any supplier of medical equipment and supplies (as defined in section 1861(oo)) unless the issu-

ance of more than one number is appropriate to identify subsidiary or regional entities under the supplier's ownership or control.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items furnished on or after July 1, 1994.

(f) DEFINITION OF INDUCEMENTS AS KICKBACKS CLARIFIED.—

(1) IN GENERAL.—Section 1128B(b)(3)(B) (42 U.S.C. 1320a–7b(b)(3)(B)) is amended by inserting before the semicolon "(except that in the case of a contract supply arrangement between a skilled nursing facility and a supplier of medical supplies and equipment (as defined in section 1861(oo) other than paragraphs (4), (6), and (7)), such employment shall not be considered bona fide to the extent that it includes tasks of a clerical and cataloging nature in transmitting to suppliers assignment rights of individuals eligible for benefits under part B of title XVIII, or performance of warehousing or stock inventory functions)".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to services furnished on or after January 1, 1994.

(g) LIMITATION ON BENEFICIARY LIABILITY.—

(1) IN GENERAL.—Section 1879 (42 U.S.C. 1395pp) is amended by adding at the end the following new subsection:

"(h) If a supplier of medical equipment and supplies (as defined in section 1861(oo))—

"(1) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1834(i);

"(2) furnishes an item or service to a beneficiary for which payment is denied in advance under section 1834(a)(15);

"(3) is excluded from participation under this title; or

"(4) furnishes an item or service to a beneficiary for which payment is denied under section 1862(a)(1);

any expenses incurred for items and services furnished to an individual by such a supplier on an unassigned basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services, unless the supplier informs the individual in advance that payment under this part will not be made for the item

or services and the individual agrees to pay for the item or service.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items or services furnished on or after July 1, 1994.

(h) STUDIES.—

(1) SUPPLIES AND SERVICES IN NURSING FACILITIES.—The Comptroller General of the United States shall conduct a study and report to the Congress no later than January 1, 1995, on the types, volume, and utilization of services and supplies furnished under contract or under arrangement with suppliers to individuals eligible for benefits under title XVIII of the Social Security Act residing in skilled nursing facilities and nursing facilities.

(2) DESCRIPTIONS RELATING TO CERTAIN CODES.—The Comptroller General of the United States shall conduct a study beginning no earlier than July 1, 1994, and report to the Congress no later than January 1, 1995, on—

(A) whether changes made by the Department of Health and Human Services to the descriptions relating to the codes for medical equipment and supplies (as defined in section

1861(oo) of the Social Security Act other than paragraphs (4), (6), and (7))—

(i) accurately reflect the items being furnished under such codes, and

(ii) are sufficiently explicit to distinguish between items of varying quality and price, and

(B) recommendations for additional changes that would improve the descriptions relating to the codes for such items.

SEC. 5. ADJUSTMENTS TO DISCRETIONARY SPENDING LIMITS.

(a) ADJUSTMENTS.—Section 251(b)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by redesignating subparagraphs (E) and (F) as subparagraphs (F) and (G), respectively, and by inserting after subparagraph (D) the following new subparagraph:

"(E) MEDICARE ADMINISTRATIVE COSTS.—To the extent that appropriations are enacted that provide additional new budget authority (as compared with a base level of $1,526,000,000 for new budget authority) for the administration of the Medicare program by fiscal intermediaries and carriers pursuant to

sections 1816 and 1842(a) of title XVIII of the Social Security Act, the adjustment for that year shall be that amount, but shall not exceed—

"(i) for fiscal year 1994, $198,000,000 in new budget authority and $198,000,000 in outlays; and

"(ii) for fiscal year 1995, $220,000,000 in new budget authority and $220,000,000 in outlays; and

the prior-year outlays resulting from these appropriations of budget authority and additional adjustments equal to the sum of the maximum adjustments that could have been made in preceding fiscal years under this subparagraph.".

(b) CONFORMING AMENDMENTS.—

(1) Section 603(a) of the Congressional Budget Act of 1974 is amended by striking "section 251(b)(2)(E)(i)" and inserting "section 251(b)(2)(F)(i)".

(2) Section 606(d) of the Congressional Budget Act of 1974 is amended—

(A) in paragraph (1)(A) by striking "section 251(b)(2)(E)(i)" and inserting "section 251(b)(2)(F)(i)"; and

(B) in paragraph (2), by inserting "251(b)(2)(E)," after "251(b)(2)(D),".

SEC. 6. STANDARDS FOR MEDICARE SUPPLEMENTAL INSURANCE POLICIES.

(a) SIMPLIFICATION OF MEDICARE SUPPLEMENTAL POLICIES.—

(1) Section 4351 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), (hereafter in this Act referred to as "OBRA–1990") is amended by striking "(a) IN GENERAL.—".

(2) Section 1882(p) (42 U.S.C. 1395ss(p)) is amended—

(A) in paragraph (1)(A)—

(i) by striking "promulgates" and inserting "changes the revised NAIC Model Regulation (described in subsection (m)) to incorporate",

(ii) by striking "(such limitations, language, definitions, format, and standards referred to collectively in this subsection as 'NAIC standards'),", and

(iii) by striking "included a reference to the NAIC standards" and inserting "were a reference to the revised NAIC Model Regulation as changed under this

subparagraph (such changed regulation referred to in this section as the '1991 NAIC Model Regulation')";

(B) in paragraph (1)(B)—

(i) by striking "promulgate NAIC standards" and inserting "make the changes in the revised NAIC Model Regulation",

(ii) by striking "limitations, language, definitions, format, and standards described in clauses (i) through (iv) of such subparagraph (in this subsection referred to collectively as 'Federal standards')" and inserting "a regulation", and

(iii) by striking "included a reference to the Federal standards" and inserting "were a reference to the revised NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '1991 Federal Regulation')";

(C) in paragraph (1)(C)(i), by striking "NAIC standards or the Federal standards" and inserting "1991 NAIC Model Regulation or 1991 Federal Regulation";

(D) in paragraphs (1)(C)(ii)(I), (1)(E), (2), and (9)(B), by striking "NAIC or Federal standards" and inserting "1991 NAIC Model Regulation or 1991 Federal Regulation";

(E) in paragraph (2)(C), by striking "(5)(B)" and inserting "(4)(B)";

(F) in paragraph (4)(A)(i), by inserting "or paragraph (6)" after "(B)";

(G) in paragraph (4), by striking "applicable standards" each place it appears and inserting "applicable 1991 NAIC Model Regulation or 1991 Federal Regulation";

(H) in paragraph (6), by striking "in regard to the limitation of benefits described in paragraph (4)" and inserting "described in clauses (i) through (iii) of paragraph (1)(A)";

(I) in paragraph (7), by striking "policyholder" and inserting "policyholders";

(J) in paragraph (8), by striking "after the effective date of the NAIC or Federal standards with respect to the policy, in violation of the previous requirements of this subsection" and inserting "on and after the effective date specified in paragraph (1)(C) (but subject to paragraph (10)), in violation of the applicable 1991

NAIC Model Regulation or 1991 Federal Regulation insofar as such regulation relates to the requirements of subsection (o) or (q) or clause (i), (ii), or (iii) of paragraph (1)(A)";

(K) in paragraph (9), by adding at the end the following new subparagraph:

"(D) Subject to paragraph (10), this paragraph shall apply to sales of policies occurring on or after the effective date specified in paragraph (1)(C)."; and

(L) in paragraph (10), by striking "this subsection" and inserting "paragraph (1)(A)(i)".

(b) GUARANTEED RENEWABILITY.—Section 1882(q) (42 U.S.C. 1395ss(q)) is amended—

(1) in paragraph (2), by striking "paragraph (2)" and inserting "paragraph (4)", and

(2) in paragraph (4), by striking "the succeeding issuer" and inserting "issuer of the replacement policy".

(c) ENFORCEMENT OF STANDARDS.—

(1) Section 1882(a)(2) (42 U.S.C. 1395ss(a)(2)) is amended—

(A) in subparagraph (A), by striking "NAIC standards or the Federal standards"

and inserting "1991 NAIC Model Regulation or 1991 Federal Regulation", and

(B) by striking "after the effective date of the NAIC or Federal standards with respect to the policy" and inserting "on and after the effective date specified in subsection (p)(1)(C)".

(2) The sentence in section 1882(b)(1) added by section 4353(c)(5) of OBRA–1990 is amended—

(A) by striking "The report" and inserting "Each report",

(B) by inserting "and requirements" after "standards",

(C) by striking "and" after "compliance,", and

(D) by striking the comma after "Commissioners".

(3) Section 1882(g)(2)(B) (42 U.S.C. 1395ss(g)(2)(B)) is amended by striking "Panel" and inserting "Secretary".

(4) Section 1882(b)(1) (42 U.S.C. 1395ss(b)(1)) is amended by striking "the the Secretary" and inserting "the Secretary".

(d) PREVENTING DUPLICATION.—

(1) Section 1882(d)(3)(A) (42 U.S.C. 1395ss(d)(3)(A)) is amended—

(A) by amending the first sentence to read as follows:

"(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title—

"(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

"(II) a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy, or

"(III) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.";

(B) by designating the second sentence as clause (ii) and, in such clause, by striking "the previous sentence" and inserting "clause (i)";

(C) by designating the third sentence as clause (iii) and, in such clause—

(i) by striking "the previous sentence" and inserting "clause (i) with respect to

the sale of a medicare supplemental policy", and

(ii) by striking "and the statement" and all that follows up to the period at the end; and

(D) by striking the last sentence.

(2) Section 1882(d)(3)(B) (42 U.S.C. 1395ss(d)(3)(B)) is amended—

(A) in clause (ii)(II), by striking "65 years of age or older",

(B) in clause (iii)(I), by striking "another medicare" and inserting "a medicare",

(C) in clause (iii)(I), by striking "such a policy" and inserting "a medicare supplemental policy",

(D) in clause (iii)(II), by striking "another policy" and inserting "a medicare supplemental policy", and

(E) by amending subclause (III) of clause (iii) to read as follows:

"(III) If the statement required by clause (i) is obtained and indicates that the individual is entitled to any medical assistance under title XIX, the sale of the policy is not in violation of clause (i) (insofar as such clause relates to such medical assistance), if a State medicaid plan

under such title pays the premiums for the policy, or, in the case of a qualified medicare beneficiary described in section 1905(p)(1), if the State pays less than the full amount of medicare cost-sharing as described in subparagraphs (B), (C), and (D) of section 1905(p)(3) for such individual.".

(3)(A) Section 1882(d)(3)(C) (42 U.S.C. 1395ss(d)(3)(C)) is amended—

(i) by striking "the selling" and inserting "(i) the sale or issuance", and

(ii) by inserting before the period at the end the following: ", (ii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(I) (other than a medicare supplemental policy to an individual entitled to any medical assistance under title XIX) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual but only if (for policies sold or issued more than 60 days after the date the statements are published or promulgated under subparagraph (D)) there is disclosed in a prominent manner as part of (or together with) the application the applicable statement (specified under subpara-

graph (D)) of the extent to which benefits payable under the policy or plan duplicate benefits under this title, or (iii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(III) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual".

(B) Section 1882(d)(3) (42 U.S.C. 1395ss(d)(3)) is amended by adding at the end the following:

"(D)(i) If—

"(I) within the 90-day period beginning on the date of the enactment of this subparagraph, the National Association of Insurance Commissioners develops (after consultation with consumer and insurance industry representatives) and submits to the Secretary a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits) which are sold to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, and

"(II) the Secretary approves all the statements submitted as meeting the requirements of subclause (I),

each such statement shall be (for purposes of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved. The Secretary shall review and approve (or disapprove) all the statements submitted under subclause (I) within 30 days after the date of their submittal. Upon approval of such statements, the Secretary shall publish such statements.

"(ii) If the Secretary does not approve the statements under clause (i) or the statements are not submitted within the 90-day period specified in such clause, the Secretary shall promulgate (after consultation with consumer and insurance industry representatives and not later than 90 days after the date of disapproval or the end of such 90-day period (as the case may be)) a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits) which are sold to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, and each such statement shall be (for purposes

of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved.".

(C) The requirement of a disclosure under section 1882(d)(3)(C)(ii) of the Social Security Act shall not apply to an application made for a policy or plan before 60 days after the date of the Secretary of Health and Human Services publishes or promulgates all the statements under section 1882(d)(3)(D) of such Act.

(4) Subparagraphs (A) and (B) of section 1882(q)(5) are amended by striking "of the Social Security Act".

(e) LOSS RATIOS AND REFUNDS OF PREMIUMS.—

(1) Section 1882(r) (42 U.S.C. 1395ss(r)) is amended—

(A) in paragraph (1), by striking "or sold" and inserting "or renewed (or otherwise provide coverage after the date described in subsection (p)(1)(C))";

(B) in paragraph (1)(A), by inserting "for periods after the effective date of these provisions" after "the policy can be expected";

(C) in paragraph (1)(A), by striking "Commissioners," and inserting "Commissioners)";

(D) in paragraph (1)(B), by inserting before the period at the end the following: ", treating policies of the same type as a single policy for each standard package";

(E) by adding at the end of paragraph (1) the following: "For the purpose of calculating the refund or credit required under paragraph (1)(B) for a policy issued before the date specified in subsection (p)(1)(C), the refund or credit calculation shall be based on the aggregate benefits provided and premiums collected under all such policies issued by an insurer in a State (separated as to individual and group policies) and shall be based only on aggregate benefits provided and premiums collected under such policies after the date specified in section 6(m)(4) of the Essential Medicare Amendments of 1993.";

(F) in the first sentence of paragraph (2)(A), by striking "by policy number" and inserting "by standard package";

(G) by striking the second sentence of paragraph (2)(A) and inserting the following: "Paragraph (1)(B) shall not apply to a policy until 12 months following issue.";

(H) in the last sentence of paragraph (2)(A), by striking "in order" and all that follows through "are effective";

(I) by adding at the end of paragraph (2)(A), the following new sentence: "In the case of a policy issued before the date specified in subsection (p)(1)(C), paragraph (1)(B) shall not apply until 1 year after the date specified in section 6(m)(4) of the Essential Medicare Amendments of 1993.";

(J) in paragraph (2), by striking "policy year" each place it appears and inserting "calendar year";

(K) in paragraph (4), by striking "February", "disllowance", "loss-ratios" each place it appears, and "loss-ratio" and inserting "October", "disallowance", "loss ratios", and "loss ratio", respectively;

(L) in paragraph (6)(A), by striking "issues a policy in violation of the loss ratio requirements of this subsection" and "such violation" and inserting "fails to provide refunds or credits as required in paragraph (1)(B)" and "policy issued for which such failure occurred", respectively; and

(M) in paragraph (6)(B), by striking "to policyholders" and inserting "to the policyholder or, in the case of a group policy, to the certificate holder".

(2) Section 1882(b)(1) (42 U.S.C. 1395ss(b)(1)) is amended, in the matter after subparagraph (H), by striking "subsection (F)" and inserting "subparagraph (F)".

(3) Section 4355(d) of OBRA–1990 is amended by striking "sold or issued" and all that follows and inserting "issued or renewed (or otherwise providing coverage after the date described in section 1882(p)(1)(C) of the Social Security Act) on or after the date specified in section 1882(p)(1)(C) of such Act.".

(f) TREATMENT OF HMO'S.—

(1) Section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by striking "a health maintenance organization or other direct service organization" and all that follows through "1833" and inserting "an eligible organization (as defined in section 1876(b)) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983,

section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 or, during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1994, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A)".

(2) Section 4356(b) of OBRA–1990 is amended by striking "on the date of the enactment of this Act" and inserting "on the date specified in section 1882(p)(1)(C) of the Social Security Act".

(g) PRE-EXISTING CONDITION LIMITATIONS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (2)(A), by striking "for which an application is submitted" and inserting "in the case of an individual for whom an application is submitted prior to or",

(2) in paragraph (2)(A), by striking "in which the individual (who is 65 years of age or older) first is enrolled for benefits under part B" and inserting "as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B", and

(3) in paragraph (2)(B), by striking "before it" and inserting "before the policy".

(h) MEDICARE SELECT POLICIES.—

(1) Section 1882(t) (42 U.S.C. 1395ss(t)) is amended—

(A) in paragraph (1), by inserting "medicare supplemental" after "If a",

(B) in paragraph (1), by striking "NAIC Model Standards" and inserting "1991 NAIC Model Regulation or 1991 Federal Regulation",

(C) in paragraph (1)(A), by inserting "or agreements" after "contracts",

(D) in subparagraphs (E)(i) and (F) of paragraph (1), by striking "NAIC standards" and inserting "standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation", and

(E) in paragraph (2), by inserting "the issuer" before "is subject to a civil money penalty".

(2) Section 1154(a)(4)(B) (42 U.S.C. 1320c–3(a)(4)(B)) is amended—

(A) by inserting "that is" after "(or", and

(B) by striking "1882(t)" and inserting "1882(t)(3)".

(i) HEALTH INSURANCE COUNSELING.—Section 4360 of OBRA–1990 is amended—

(1) in subsection (b)(2)(A)(ii), by striking "Act" and inserting "Act)";

(2) in subsection (b)(2)(D), by striking "services" and inserting "counseling";

(3) in subsection (b)(2)(I), by striking "assistance" and inserting "referrals";

(4) in subsection (c)(1), by striking "and that such activities will continue to be maintained at such level";

(5) in subsection (d)(3), by striking "to the rural areas" and inserting "eligible individuals residing in rural areas";

(6) in subsection (e)—

(A) by striking "subsection (c) or (d)" and inserting "this section",

(B) by striking "and annually thereafter, issue an annual report" and inserting "and annually thereafter during the period of the grant, issue a report", and

(C) in paragraph (1), by striking "Statewide";

(7) in subsection (f), by striking paragraph (2) and by redesignating paragraphs (3) through (5) as paragraphs (2) through (4), respectively; and

(8) by redesignating the second subsection (f) (relating to authorization of appropriations for grants) as subsection (g).

(j) TELEPHONE INFORMATION SYSTEM.—

(1) Section 1804 (42 U.S.C. 1395b–2) is amended—

(A) by adding at the end of the heading the following: "; MEDICARE AND MEDIGAP INFORMATION",

(B) by inserting "(a)" after "1804.", and

(C) by adding at the end the following new subsection:

"(b) The Secretary shall provide information via a toll-free telephone number on the programs under this title.".

(2) Section 1882(f) (42 U.S.C. 1395ss(f)) is amended by adding at the end the following new paragraph:

"(3) The Secretary shall provide information via a toll-free telephone number on medicare supplemental policies (including the relationship of State programs under title XIX to such policies).".

(3) Section 1889 is repealed.

(k) MAILING OF POLICIES.—Section 1882(d)(4) (42 U.S.C. 1395ss(d)(4)) is amended—

(1) in subparagraph (D), by striking ", if such policy" and all that follows up to the period at the end, and

(2) by adding at the end the following new subparagraph:

"(E) Subparagraph (A) shall not apply in the case of an issuer who mails or causes to be mailed a policy, certificate, or other matter solely to comply with the requirements of subsection (q).".

(l) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of OBRA–1990; except that—

(1) the amendments made by subsection (d)(1) shall take effect on the date of the enactment of this Act, but no penalty shall be imposed under section 1882(d)(3)(A) of the Social Security Act (for an action occurring after the effective date of the amendments made by section 4354 of OBRA–1990 and before the date of the enactment of this Act) with respect to the sale or issuance of a policy which is not unlawful under section 1882(d)(3)(A)(i)(II) of the Social Security Act (as amended by this section);

(2) the amendments made by subsection (d)(2)(A) and by subparagraphs (A), (B), and (E)

of subsection (e)(1) shall be effective on the date specified in subsection (m)(4); and

(3) the amendment made by subsection (g)(2) shall take effect on January 1, 1994, and shall apply to individuals who attain 65 years of age or older on or after the effective date of section 1882(s)(2) of the Social Security Act (and, in the case of individuals who attained 65 years of age after such effective date and before January 1, 1995, and who were not covered under such section before January 1, 1995, the 6-month period specified in that section shall begin January 1, 1995).

(m) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in

this subsection referred to as the "NAIC") modifies its 1991 NAIC Model Regulation (adopted in July 1991) to conform to the amendments made by this section and to delete from section 15C the exception which begins with "unless", such modifications shall be considered to be part of that Regulation for the purposes of section 1882 of the Social Security Act.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such modifications shall be considered to be part of that Regulation for the purposes of section 1882 of the Social Security Act.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

(ii) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 7. EXPANSION AND REVISION OF MEDICARE SELECT POLICIES.

(a) PERMITTING MEDICARE SELECT POLICIES IN ALL STATES.—

(1) IN GENERAL.—Subsection (c) of section 4358 of OBRA–1990 is hereby repealed.

(2) CONFORMING AMENDMENT.—Section 4358 of OBRA–1990 is amended by redesignating subsection (d) as subsection (c).

(b) REQUIREMENTS OF MEDICARE SELECT POLICIES.—Section 1882(t)(1) of the Social Security Act (42 U.S.C. 1395ss(t)(1)) is amended to read as follows:

"(1)(A) If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that—

"(i) the benefits under such policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), and

"(ii) in the case of a policy described in subparagraph (C)(i)—

"(I) the benefits under such policy are not one of the groups or packages of benefits described in subsection (p)(2)(A),

"(II) except for nominal copayments imposed for services covered under part B of this title, such benefits include at least the core group of basic benefits described in subsection (p)(2)(B), and

"(III) an enrollee's liability under such policy for physician's services covered under part B of this title is limited to the nominal copayments described in subclause (II),

the policy shall nevertheless be treated as meeting those standards if the policy meets the requirements of subparagraph (B).

"(B) A policy meets the requirements of this subparagraph if—

"(i) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy,

"(ii) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network,

"(iii) the network offers sufficient access,

"(iv) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network,

"(v)(I) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of—

"(aa) the restrictions on payment under the policy for services furnished other than by or through the network,

"(bb) out of area coverage under the policy,

"(cc) the policy's coverage of emergency services and urgently needed care, and

"(dd) the availability of a policy through the entity that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation without regard to this subsection and the premium charged for such policy, and

"(II) each enrollee prior to enrollment acknowledges receipt of the explanation provided under subclause (I), and

"(vi) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the 1991

Model NAIC Regulation or 1991 Federal Regulation and other requirements of this section without regard to this subsection.

"(C)(i) A policy described in this subparagraph—

"(I) is offered by an eligible organization (as defined in section 1876(b)),

"(II) is not a policy or plan providing benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, and

"(III) provides benefits which, when combined with benefits which are available under this title, are substantially similar to benefits under policies offered to individuals who are not entitled to benefits under this title.

"(ii) In making a determination under subclause (III) of clause (i) as to whether certain benefits are substantially similar, there shall not be taken into account, except in the case of preventive services, benefits provided under policies offered to individuals who are not entitled to benefits under this title which are in addition to the benefits covered by this title and which are benefits an entity must

provide in order to meet the definition of an eligible organization under section 1876(b)(1).".

(c) RENEWABILITY OF MEDICARE SELECT POLICIES.—Section 1882(q)(1) of the Social Security Act (42 U.S.C. 1395ss(q)(1)) is amended—

(1) by striking "(1) Each" and inserting "(1)(A) Except as provided in subparagraph (B), each";

(2) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new subparagraph:

"(B)(i) Except as provided in clause (ii), in the case of a policy that meets the requirements of subsection (t), an issuer may cancel or nonrenew such policy with respect to an individual who leaves the service area of such policy.

"(ii) If an individual described in clause (i) moves to a geographic area where an issuer described in clause (i), or where an affiliate of such issuer, is issuing medicare supplemental policies, such individual must be permitted to enroll in any medicare supplemental policy offered by such issuer or affiliate that provides benefits comparable to or less than the benefits provided in the policy being can-

celed or nonrenewed. An individual whose coverage is canceled or nonrenewed under this subparagraph shall, as part of the notice of termination or nonrenewal, be notified of the right to enroll in other medicare supplemental policies offered by the issuer or its affiliates.

"(iii) For purposes of this subparagraph, the term 'affiliate' shall have the meaning given such term by the 1991 NAIC Model Regulation.".

(d) CIVIL MONEY PENALTY.—Section 1882(t)(2) of the Social Security Act (42 U.S.C. 1395ss(t)(2)) is amended—

(1) by striking "(2)" and inserting "(2)(A)";

(2) by redesignating subparagraphs (A), (B), (C), and (D) as clauses (i), (ii), (iii), and (iv), respectively;

(3) in clause (iv), as so redesignated—

(A) by striking "paragraph (1)(E)(i)" and inserting "paragraph (1)(B)(v)(I), and

(B) by striking "paragraph (1)(E)(ii)" and inserting "paragraph (1)(B)(v)(II)";

(4) by striking "the previous sentence" and inserting "this subparagraph"; and

(5) by adding at the end the following new subparagraph:

"(B) If the Secretary determines that an issuer of a policy approved under paragraph (1) has made a misrepresentation to the Secretary or has provided the Secretary with false information regarding such policy, the issuer is subject to a civil money penalty in an amount not to exceed $100,000 for each such determination. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(e) EFFECTIVE DATES.—

(1) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (hereafter in this subsection referred to as the "NAIC") makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference

to the 1991 NAIC Model Regulation (as so defined) as changed under this paragraph (such changed Regulation referred to in this subsection as the "1994 NAIC Model Regulation").

(2) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model Regulation (as so defined) within the 6-month period specified in subsection (e), the Secretary of Health and Human Services (hereafter in this subsection referred to as the "Secretary") shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted in June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this paragraph (such changed Regulation referred to in this subsection as the "1994 Federal Regulation").

(3) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State adopts the 1994 NAIC Model Regulation or the 1994 Federal Regulation; or

(ii) 1 year after the date the NAIC or the Secretary first adopts such regulations.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1994 NAIC Model Regulation or the 1994 Federal Regulation, but

(ii) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session

shall be deemed to be a separate regular session of the State legislature.

SEC. 8. PSYCHOLOGY SERVICES IN HOSPITALS.

Section 1861(e)(4) (42 U.S.C. 1395x(e)(4)) is amended by striking "physician;" and inserting "physician, except that a patient receiving qualified psychologist services (as defined in subsection (ii)) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law;".

SEC. 9. PAYMENT FOR ANESTHESIA SERVICES FURNISHED DIRECTLY OR CONCURRENTLY TO PATIENTS IN PROVIDERS.

(a) PAYMENT FOR ANESTHESIA SERVICES FURNISHED DIRECTLY OR CONCURRENTLY TO PATIENTS IN PROVIDERS.—After consultation with representatives from professional associations of certified registered nurse anesthetists and anesthesiologists, the Secretary of Health and Human Services shall determine conditions for payment for anesthesia services furnished directly or concurrently to patients in a provider in accordance with the requirements of subsection (b), without regard to section 405.552(a) of title 42, Code of Federal Regulations (and without regard to any other regulation, ruling, or decision reaching the same result as, or a result similar to, the

result set forth in such section), and with full regard to section 405.550 of such title.

(b) REQUIREMENTS.—The requirements of this subsection are that the conditions for such payment—

(1) shall not restrict certified registered nurse anesthetists, who work with anesthesiologists, from performing all the components of the anesthesia service that such anesthetists are legally authorized to perform;

(2) shall not encourage the use of 2 anesthesia providers in cases when it is not medically justified; and

(3) shall prevent fraud and abuse in payment for anesthesia services.

SEC. 10. IMPROVED REIMBURSEMENT FOR CLINICAL SOCIAL WORKER SERVICES UNDER MEDICARE.

(a) IN GENERAL.—Section 1833(a)(1)(F)(ii) (42 U.S.C. 1395l(a)(1)(F)(ii)) is amended to read as follows: "(ii) the amount determined by a fee schedule established by the Secretary.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective with respect to payments made for clinical social worker services furnished on or after January 1, 1994.

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